Senate Budget & Fiscal Review

Senator Wesley Chesbro, Chair

Subcommittee No. 3
on
Health, Human Services, Labor, & Veterans Affairs

Senator Wesley Chesbro, Chair
Senator Gilbert Cedillo
Senator Tom McClintock
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May 10th, 2004
1:30 PM
Room 112

Item	*Description*
4440	**Department of Mental Health—*Selected Issues as Noted***
4260	**Department of Health Services--*Selected Issues as Noted***

PLEASE NOTE: **Only those items contained in this agenda will be discussed in the hearing. Issues will be discussed in the order as noted in the Agenda unless otherwise determined by the Chair.**

All remaining budget issues for the DHS and DMH will be reviewed at the Subcommittee's May 21st and 22nd May Revision hearings. ***Please see the Senate File for dates and times of these hearings***.

I. Vote Only Calendar (All Items as Listed Below)

4440 Department of Mental Health

1. Reduction to Substance Abuse & Mental Health Services Administration Block Grant

Background and Finance Letter: The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has notified the DMH that the federal block grant is being decreased from $55.6 million to $54.5 million, or a decrease of $1.1 million (federal funds) for fiscal year 2004-05.

To account for this reduction, the Administration is proposing a decrease of $1.1 million (federal funds) for the last year of the Youth Development and Crime Reduction Demonstration projects. The Administration notes that reducing these projects will be the least disruptive and avoids having to reduce base allocations for counties overall.

Subcommittee Staff Comment and Recommendation: It is unfortunate that the federal government is reducing California's grant funds. Given this reduction, the Administration's decision to reduce demonstration projects appears to be the best alternative. As such, Subcommittee staff has raised no issues with this proposal.

Budget Issue: Does the Subcommittee want to **adopt the Administration's Finance Letter?**

2. Projects for Assistance in Transition from Homelessness (PATH) Formula Grant

Background and Finance Letter: PATH provides funding to assist persons who are homeless (or at risk of becoming homeless) and have a mental illness. Counties receiving PATH funds must annually develop a service plan and budget for utilization of the funds. The service plan must describe each program setting and the services and activities to be provided. Allowable services include service coordination, alcohol and drug treatment, community mental health, housing services, supportive services in residential settings, and staff training.

The federal government has notified California that an additional $1 million (federal funds) will be available for PATH for a total amount $6.7 million (federal funds). As such the Administration has submitted a Finance Letter requesting an augmentation in this amount.

Subcommittee Staff Comment and Recommendation: Subcommittee staff concurs with the request and has raised no issues with this proposal.

Budget Issue: Does the Subcommittee want to **adopt the Administration's Finance Letter?**

3. Budget Bill Language—Capital Outlay Related to Metropolitan State Hospital

Background and Governor's Finance Letter Request: The Administration is requesting that Item 4440-496 be included in the Budget Bill to revert $3.873 million (Public Building Construction Fund) from Item 4440-301-660 of the Budget Act of 2003 for the Metropolitan State Hospital project—construct new kitchen and remodel satellite service kitchens. This project consists of design and construction of a new kitchen building and renovation of satellite serving kitchens in several buildings throughout the hospital campus.

This funding needs to be reverted because the nature of the improvements are not compatible with lease-revenue financing as originally was thought when they were budgeted in the 2003-04 fiscal year. As such, the Governor's proposed budget utilizes General Fund support for this purpose.

Budget Issue: Does the Subcommittee want to **adopt the Administration's Finance Letter?**

4. Budget Bill Language—Capital Outlay Related to Patton State Hospital

Background and Governor's Finance Letter Request: The Administration is seeking to add Item 4440-491 to the Budget Bill in order to re-appropriate $228,000 (Public Construction Fund) for improvements related to fire and life safety concerns at Patton State Hospital for the admissions suite and EB Building. According to the Administration, the use of these funds is consistent with the scope and purposes identified in the Legislative Analyst's Office Supplemental Reporting Language as contained in the Budget Act of 2003.

Budget Issue: Does the Subcommittee want to **adopt the Administration's Finance Letter?**

5. Budget Bill Language—Capital Outlay Related to Metropolitan State Hospital

Background and Governor's Finance Letter Request: The Administration is seeking to add Item 4440-491 to the Budget Bill in order to re-appropriate $6.7 million (Public Construction Fund) for constructing a school building at Metropolitan State Hospital. The Administration states that this re-appropriation is needed due to a delay in the start of the working drawings phase of the project.

Budget Issue: Does the Subcommittee **want to adopt the Administration's Finance Letter?**

II. Items for Discussion

A. 4440 Department of Mental Health

1. Status Update--Administration's Proposal for the EPSDT Program for Mental Health ISSUES "A" and "B"

Background—Overall: **Most children receive Medi-Cal services through the EPSDT Program**. Specifically, EPSDT is a federally mandated program that requires states to provide Medicaid (Medi-Cal) **recipients under age 21 *any* health or mental health service that is medically necessary** to correct or ameliorate a defect, physical or mental illness, or a condition identified by an assessment, **including services not otherwise included in a state's Medicaid (Medi-Cal) Plan.**

Though the DHS is the "single state agency" responsible for the Medi-Cal Program**, mental health services including those provided under the EPSDT, have been delegated to be the responsibility of the Department of Mental Health (DMH)**. Further, **counties are responsible for providing, arranging and managing Medi-Cal mental health services under the supervision of the DMH and DHS. However, eligibility and the scope of services to which eligible children are entitled, are *not* established at the local level.**

Types of Services: The state uses the term **"EPSDT supplemental services**" to refer to EPSDT services which are required by federal law **but are not otherwise covered under the state Medi-Cal Plan for adults**. **Examples of services include family therapy, crisis intervention, medication monitoring, and behavioral management modeling.**

EPSDT Litigation—State Has Settlement Agreements: In 1990, a national study found that **California ranked 50th** among the states in identifying and treating severely mentally ill children. **Subsequently due to litigation (T.L. v Belshe' 1994)**, the DHS was required to expand certain EPSDT services, including outpatient mental health services. The 1994 court's conclusion **was reiterated again in 2000 with respect to additional services (i.e., Therapeutic Behavioral Services—TBS) being mandated.**

Further in January 2004, the U.S. District Court issued an Interim Order clarifying an earlier ruling regarding the provision of TBS that also required outreach, monitoring and related provisions to ensure that children receive EPSDT services as needed. The Court agreed that TBS utilization was too low statewide and ordered the parties to collaborate to develop a plan to increase TBS approvals.

EPSDT Funding Process—Both County and State Funds Used To Draw Federal Match: The DHS and DMH **crafted an interagency agreement in 1995 to implement expanded services as required by the court.**

Generally, this *original* agreement required County MHPs to provide a "baseline" amount using County Realignment Funds (essentially a county "maintenance-of-effort**") and then the state was responsible for providing the nonfederal share of the growth in the program.**

The baseline amount is established for each county based on a formula. For 2004-2005, the baseline is $65.7 million, plus an additional 10 percent county match ($20 million for the budget year) which was instituted in the Budget Act of 2002, for a total of $85.7 million (County Realignment Funds). The state will provide funding (via Medi-Cal) for costs above this amount (above the baseline and 10 percent match).

The General Fund dollars and accompanying federal matching funds are budgeted in the DHS and are transferred to the DMH as reimbursements. **The DMH distributes EPSDT funds to the County MHPs responsible for the provision of specialty mental health in each county. Final payment is based on cost settled actual allowable costs, or rates.**

Prevalence Rate for California: Based on a number of studies which estimate the prevalence of children exhibiting various levels of functional impairment, **it is estimated that 20 percent of children suffer from diagnosable mental disorder, and up to 13 percent of these children are estimated to be seriously emotionally disturbed. Given these estimates it is likely that between 500,000 to 1.3 million children and adolescents in California have a severe emotional disturbance.**

As a comparison, the actual statewide average EPSDT penetration rate was 5.29 percent as of 2001-02 and 5.32 percent as of 2002-03.
It should be noted that the **Little Hoover Commission's report** (October 2001) on the existing inadequacies in the children's mental health system considered the potential savings if children's mental health utilization increased by 10 percent—the estimated prevalence rate. In one year, they estimated that California would save $44 million in juvenile justice, $27 million in CYA costs, $78 million in residential treatment and $1.4 million at Metropolitan State Hospital. **A total of $110 million in savings!**

Governor's Proposed Budget Overall: Under the Governor's budget, state support for EPSDT would grow to $365 million (General Fund) in 2004-05, for an **increase of about $112 million (General Fund)** compared to the current year. **This proposed spending level takes into account several technical adjustments, as referenced below, as well as three proposals intended to slow growth in the program and to potentially limit access to EPSDT services.**

The budget proposes the following adjustments to the EPSDT Program:

Technical Baseline Adjustments in Budget (increase of $47.9 million General Fund):

- ***Accrual to Cash:*** Makes an adjustment of $27.8 million (General Fund) in the budget year to reflect the one-time only reduction from 2003-04 which pertained to shifting the Medi-Cal Program from an accrual to cash basis.
- **Federal Medi-Cal Match:** Makes an increase of $ 20.1 million (General Fund) in the budget year to reflect a reduction in the share of costs that is supported by the federal

government (Medicaid federal match percentage). In 2003-04 a congressional relief package for states temporarily increased the federal cost-sharing ratio.

Governor's Reduction Proposals:

- ***"Re-Basing" Provider Rates:*** The Administration proposes to change how provider rates are calculated (referred to as "re-basing") for **savings of $60 million ($40 million General Fund) in the EPSDT** and an additional reduction of $50 million (federal funds) for adult outpatient services. **This issue is discussed below (i.e., Issue "A").**
- ***EPSDT Program Audits by the DMH:*** The DMH contends that savings of $13 million ($6.4 million General Fund) can be achieved from conducting additional audits of counties and their contractors who provide mental health services. The DMH is seeking an increase of $1.7 million ($844,000 General Fund) to hire consultants to conduct this audit work. **This issue is discussed below (i.e., Issue "B").**
- ***EPSDT Waiver for Medical Necessity:*** As part of their overall Medi-Cal 1115 Waiver proposal, the Administration is also proposing a Waiver regarding the EPSDT Program. Though details are significantly lacking, the Administration purports to making changes to how "medical necessity" is defined with respect to EPSDT services. The DMH is seeking an increase of $472,000 ($236,000 General Fund) to hire a consultant ($300,000) and to support two new state staff. **This proposal was rejected by the Subcommittee as noted below in the March 22nd hearing.**

Prior Subcommittee Hearing—March 22nd: In the March 22nd hearing, **the Subcommittee rejected the Administration's proposal** to provide an increase of $472,000 ($236,000 General Fund) to hire a consultant and to support new state staff to proceed with a Waiver to redefine medical necessity for EPSDT services provided through County Mental Health Plans (MHPs). **Further, the Subcommittee directed that if the Administration wants to proceed with a Waiver in this area, they would need to introduce policy legislation and not proceed with trailer bill legislation. Therefore, this issue is closed out.**

ISSUES "A" and "B" are discussed below.

ISSUE "A" for the EPSDT Program-–—Re-Basing Provider Rates

Background—Existing Rate Structure: Under the Medi-Cal Program there are reimbursement limits. Since EPSDT is a Medi-Cal Program that provides mental health specialty services, it uses different reimbursement limits than other Medi-Cal programs. In some instances County Mental Health Plans negotiate rates with providers. **In other cases, the reimbursement rate is based on the *lowest* of:**

- The **"State Maximum Allowable" cost**, as defined by the DMH and approved by the DHS and federal government;
- The provider's allowable cost; ***or***
- The provider's published charge to the general public, unless the provider is a nominal charge provider.

Most of the reimbursement provided under EPSDT is done through the State Maximum Allowable cost process.

***The State's Maximum Allowable Rate*: The existing "state maximum allowable" (SMA) rate structure is based on 1989-90 cost report data which has been updated annually using cost-of-living-adjustments.** This rate structure is contained within California's State Medicaid (Medi-Cal) Plan submitted to the federal government in 1993. **This Plan also provided that the state would update rates annually until they were "re-based in no more than three years using more current actual cost information". The DMH however has never updated these rates.**

According to the DMH, under the existing rate structure, (1) about 34 percent of all "Short-Doyle" inpatient psychiatric facilities are receiving *less* than their cost, and (2) about 11 percent of all outpatient specialty mental health services are receiving less than their cost.

Governor's Budget Proposal to Re-base Rates: The Governor's budget proposes to reduce the EPSDT Program **by $60 million ($40 million General Fund) and $25 million in federal funds for adult outpatient services.**

It should be noted that this re-basing proposal actually would reduce federal funds by *another $45 million* than assumed in the Governor's budget. However, the budget also assumes that California can obtain approval through a State Plan Amendment to obtain a *"public provider exemption"* for federal funds to be provided *above* California's State Maximum Allowable rate. The federal government has provided this type of exemption before. In essence, the federal reimbursement would be cost-based and not reliant on the State Maximum Allowable rate.

Subcommittee Staff Comment—Proposal is Flawed: **This budget proposal has caused grave concern because the proposed methodology *is fundamentally flawed.*** The proposed re-basing calculation would set the State Maximum Allowable rates based upon the average rates of each type of service using 2001-02 data, updated by COLAs to 2004-05. **However, the average rate is determined (1) after eliminating rates in excess of one standard deviation from the mean, and (2) after the top ten percent of providers with the highest rate are eliminated from the base data to afford cost containment.**

According to the DMH, under this proposed re-basing structure, (1) about 42 percent of all "Short-Doyle" inpatient psychiatric facilities would be receiving less than their cost, and (2) about 47 percent of all outpatient specialty mental health services would be receiving *less* than their cost. As such, this methodology would continually lower rates, whether justified or not.

According to mental health service experts, it is highly unlikely that productivity gains and other program efficiencies can be achieved to meet the significantly lower reimbursement rates. This is particularly true for group services such as day treatment and residential programs. **Many County MHPs have already made significant gains in productivity for individual services.**

The proposal also assumes that the cost of providing services is uniform throughout the state. **It has been well documented that rural areas and large urban areas have higher cost factors that often need to be taken into consideration.**

The bottom-line is that the Administration's re-basing proposal is simply a cost-shift to the County MHPs and/or providers when efficiencies or cost reductions cannot be made. Further, some providers are likely to discontinue services which will likely impact access.

Other potential options are available in lieu of doing the Administration's re-basing proposal.

EPSDT Rate of Growth Slow Down: It should also be noted that the rate of growth under EPSDT has shown recent signs of slowing down considerably. **The DMH January budget estimate assumed a growth rate of 16 percent, *where as recent actual data for EPSDT shows a growth rate of only 8 percent.***

Other Options Are Available: Based on conversations with the DMH and others, it appears that **other options are available** than what has thus far been proposed. **It should be noted however, that *any* option which reduces state General Fund support will result in a cost shift to the County MHPs and/or providers when efficiencies or cost reductions cannot be made.**

Some Other Potential Options for Reducing General Fund

- **Increase the share-of-cost currently paid by County MHPs** from its current 10 percent above the 2001-02 growth to a higher percentage (in lieu of re-basing proposal).
- **Re-base the State Maximum Allowable using a *different* averaging methodology**.

Strategies to Preserve Federal Funds

- **Implement the Public Provider exemption** which enables public entities to obtain increased federal funds. This requires a State Plan Amendment and federal approval.
- **Revise the Cost Settlement process** by establishing the County MHPs as the "sole provider" whereby contract providers are treated as purchased services of the Mental Health Plan. (This is similar to other managed care plans that have the ability to purchase services from individual providers as part of their network of services.

It should be noted that all of these options, like the one proposed by the Administration through the budget, are complex and have their nuisances.

DMH Convenes Meeting to Discuss Re-basing Concept and Other Options (See Hand Out):
The DMH convened a stakeholders meeting (April 29, 2004) regarding their re-basing proposal to solicit comments and seek additional options. A summary of these comments are contained in the Hand Out Package.

Subcommittee Request and Questions: The Subcommittee has requested the DMH to respond to the following questions:

- **1.** Please **summarize the comments from the April 29th stakeholders** meeting as contained in the Hand Out.
- **2.** May the DMH be modifying the proposal at May Revision to address some of these comments?
- **3.** Generally, **what might some additional alternatives be to draw down additional federal funds in this area?**

Budget Issue: Does the **Subcommittee want to hold this issue OPEN pending receipt of the May Revision?**

ISSUE "B"--EPSDT Program Audits by the DMH

Background—Previous Cost Containment Actions: EPSDT is a federal entitlement under the state's Medi-Cal Program. Due to litigation, as discussed under the background section above, the program operates under a settlement agreement with both the state and County MHPs paying the non-federal share of the program. In the Budget Act of 2002, a 10 percent county match on the growth of the total state matching fund requirement above the 2001-02 level was implemented.

In addition, trailer bill legislation accompanying the Budget Act of 2002 required the DMH to ensure statewide application of managed care principles to the EPSDT Program. Regulations to implement this required were endorsed by the Secretary of State in November 2003. It appears that these recent changes may be having an effect on slowing the rate of growth within the EPSDT.

EPSDT Rate of Growth Slow Down: It should also be noted that the rate of growth under EPSDT has shown recent signs of slowing down considerably. **The DMH January budget estimate assumed a growth rate of 16 percent,** ***where as recent actual data for EPSDT shows a growth rate of only 8 percent.***

Governor's Budget Proposal and Recent Change to Proposal: The Governor proposes **an increase of $1.7 million ($844,000 General Fund) to hire contractors to conduct additional reviews and oversight of EPSDT Program expenditures, and assumes savings of $13 million ($6.5 million General Fund) from these audit efforts.**

The request for funding the contract audit staff originally assumed that over 300 legal entities that provide EPSDT services would be reviewed on a three-year cycle beginning in 2004-05. **This original proposal assumed a sample size representing almost 90 percent of the total paid claims from 2002-03. However, the DMH is now changing their selection criteria after meeting with stakeholder organizations. An outline of this revised criteria is contained in the Hand Out Package.**

The estimated savings level remains the same as was contained in the Governor's proposed budget. The estimated savings level contained in the budget was derived by taking the approved claims amount from 2002-03 and dividing by three (since one-third of the entities will be audited each year), then reducing by 11 percent to reflect the dollars that will not be subject to the review. **The DMH then applied a 5.6 percent disallowance (i.e., savings level) to this amount.** This 5.6 percent rate is what was identified through recent audits conducted on Therapeutic Behavioral Services (TBS) reviews. **In essence, the estimated savings level represents about two percent of the total EPSDT Program for 2002-03, the year that will be initially audited.**

Further, the Administration's proposal assumes ***that the state will collect any disallowances directly from the County MHPs, even if a private provider is responsible for the audit exception.***

Subcommittee Request and Questions: The Subcommittee has requested the DMH to respond to the following questions:

- **1. Please describe the revised sampling methodology in detail, including the audit selection process and criteria, and how the criteria will be applied.**
- **2. Please explain how the audit results will be applied to the County Mental Health Plans. What methods of recoupment will be applied?**
- **3. Will the results from the audits be made available for improving the quality of services at all?**

Budget Issue: Does the Subcommittee **want to hold OPEN the Administration's revised proposal pending receipt of the May Revision?**

B. 4260 Department of Health Services

1. DHS Not Reimbursing for Services Provided by Some Contractors

Constituency Concerns: The Subcommittee **has received dozens of letters** expressing significant concerns regarding the complete lack of reimbursement for services rendered under a wide variety of contracts, principally in the public health area.

Many of these contracts-- for such services as provided under Local Health Jurisdictions, the Male Involvement Program, HIV/AIDS information and referral hotline, and HIV treatment services, among others—are for services that are on-going in nature, have funds appropriated for them, and received letters from the DHS notifying them that services should commence as of July, 2003 (for current year functions) and that contract extensions would be forthcoming. Due to historical delays in the state contracting process, the contractors thought it was "business as usual"—they would provide the services and front the cash flow until the state began reimbursing them.

As such, many organizations have provided services and have not been paid for them for almost an entire fiscal year. Contractors have been providing the DHS with the required documentation of expenditure reports for services rendered but still have not been paid. Further, these contractors did not received any notice of termination for services from the state, as such they continued to provide the services ("in good faith") as required in the DHS contracts.

Background on DHS Contract Process: According to the DHS, **they process about 3,000 contracts annually.** The processing time associated with contract development and approval varies considerably and is a function of the contract type, program staff workload, contract staff workload, the complexity of the contract, and the contractors' approval process. **The large volume of contracts processed by the DHS, coupled with other factors such as additional Department of General Services contract requirements, vacant positions and reduced positions, limits their ability to respond effectively and has resulted in an elongated contract process with delays. As such, many contracts were not fully processed as of December 2003 for the 2003-04 fiscal year (July 1 2003 to June 30, 2004).**

This already potentially lengthy process has been made even more difficult by a new approval process associated with obtaining a contract ban exemption (as discussed below).

DOF Budget Letter Number 03-43)—Limits Contracts (See Hand Out): As noted in a Budget Letter from the Department of Finance, **Executive Order S-4-03** was signed by the Governor on December 5, 2003 to prohibit state agencies and departments from **(1) entering into any new service contract or making any changes to an existing contract that would increase the amount or *extend the term* of *any* contract**, or **(2)** entering into any new contracts or agreements to lease or purchase equipment.

The letter also provides for *exemptions as referenced in the letter*. This list, among other things, includes the following:

(1) Activities *specifically required by statute*;
(2) Purchases of prescription drugs and *medically necessary services*, and
(3) Activities that are not funded by the General Fund, as long as the fund is solvent and would not lead to a fee increase.

Any department requesting an exemption would need to proceed with an Exemption Form (referred to as a "DF-170") and receive the Department of Finance's (DOF) approval. Under this process, departments must submit a request for exemption through their respective agency (in this case the Health and Human Services Agency) to the DOF for approval before the contract can be approved and submitted to the Department of General Services (DGS) for processing.

Subcommittee Staff Comment: In reviewing many of the letters submitted by DHS contractors who have not received reimbursement, it appears that some of the contracts were **for extensions (i.e., the DHS provided formal notification to current contractors to extend for one more year to June 30, 2004). This is because contracts are often done for two or three years and contain contingency clauses (such as services must be provided at the same rate as prior year and that an appropriation is provided for the program).** (An example is contained in the Hand Out package.)

In addition, it appears that many of the services rendered pertain to either (1) statutorily required services, or (2) medically necessary services. As such, it would appear that exemptions would be in order.

Further, it appears that most of the rendered services would also be potentially eligible for submitting a claim to the Government Claims Program of the Victim Compensation and Government Claims Board (Board) since services were provided in good faith. Specifically, the Board resolves claims filed against the State of California alleging a legal liability on the part of the state as well as claims requesting equitable consideration for damages when the claimant may have no legal remedy. The Board also administers special programs mandated by the Legislature for the purpose of providing appropriate specified financial relief for citizens who have incurred damages due to natural disasters, **or through the actions or inactions of state government.** Pursuant to Government Code Sections 900 - 965.9, any person may file a claim with the Board for money or damages against a state agency under the California Tort Claims Act.

Finally, this process raises the question of trust in future business dealings—i.e., why would Local Health Jurisdictions and other contractors ever again provide any services in "good faith" until fully executed contracts are completed? If it takes the DHS and DGS several months to

complete contracts before services can be rendered, then individuals who need services will most certainly suffer.

Subcommittee Request and Questions: The Subcommittee has requested the DOF and DHS to respond to the following questions:

- **1. DOF, Please describe the need for the contract freeze. How much General Fund savings is to be attributable to this process? What about increased administrative processing costs?**
- **2. DOF**, **How is medical necessity determined with respect to the DHS' request for contract exemptions?** For example, why would a contract for training health care organizations to offer outreach to sexually active people who are diagnosed with HIV/AIDS, not be considered medically necessary?
- **3. DOF, Aren't many contractors at risk since they are providing services in good faith and are not sure if they will be reimbursed?**
- **4. DOF, How long will this process continue and what happens if it is not rectified before the start of the new fiscal year?**
- **5. DHS Please describe your process for obtaining contract exemptions**—i.e., what types of situations, the process required, and the general timeframe it has taken to complete.
- **6. How many contracts has (does) the DHS need to request an exemption on**? Do most of the requested exemptions pertain to specific programs or a wide variety of programs? Can't an exemption be obtained for a specific program area in lieu of individual contracts if they are the same (such as a one-year extension)?
- **7. Have any requests for exemptions been *denied* after the contractor has already provided services as required in the contract? If so, who are these contractors and what other recourse may be available to them?**
- **8. For those contractors who are approved for exemption, what exactly is the schedule for reimbursement since payments are late?**

2. Genetic Disease Testing Fund—ISSUES "A", "B", and "C"

Overall Background on Newborn Screening Program and Prenatal Screening Program: The Genetic Disease Branch is responsible for the management and operation of **two screening programs—the Newborn Screening Program and the Prenatal Screening Program. Both of these programs provide clinical analyses to prevent the occurrence, or ameliorate the effects, of certain disorders.** Newborns are screened for a series of heritable preventable metabolic disorders. The Prenatal Screening Program screens pregnant women for neural tube defects and chromosomal abnormalities.

The Newborn Screening Program screens **about 525,000 infants, or 99 percent of the annual births, in about 325 maternity hospitals.** The Prenatal Screening Program **screens over 350,000 pregnancies annually and serves about 7,000 prenatal care providers.**

Summary of Fee Adjustments: All screening is fee supported. Fees are collected from individuals, their health insurance, hospitals, birthing centers and Medi-Cal. All fee collections are deposited in the Genetic Disease Testing Fund. **As noted by the DHS, efficient collection of fees is critical to program operations and solvency of the fund.** Fee changes require regulatory action by the DHS. **Here is a summary of the fee adjustments:**

Newborn Screening Program	**Adjustment**	**Total Fee Amount**
1991	$5	$35
1993	$5	$40
1994	$2	$42
Jan 2002	$14	$56
July 2002 to Present	$4	$60
Prenatal Screening Program	**Adjustment**	**Total Fee Amount**
1986		$40
1999	$9	$49
1992	$4	$53
1993	$2	$55
1994-Present	$2	$57
Expanded Prenatal Screening	**Adjustment**	**Total Fee Amount**
1995		$115
1998-Present	($10)	$105

It should also be noted that due to a shortfall in the fund, in the Budget Act of 2002 a General Fund loan of $5 million was provided for program operations. (This loan is separate and apart from the two other General Fund loans provided for the Screening Information System (SIS) Project discussed below).

Lack of Clarity on Status of Genetic Disease Testing Fund Reserve: **The Governor's proposed January budget estimates a reserve of $4.3 million (Genetic Disease Testing Fund) as of 2004-05. However, an updated fund condition statement provided by the Administration as of April, reflects a reserve of only $2.3 million, *or $2 million less* than shown in the proposed budget.**

ISSUE "A" Screening Information System (SIS)

Background—SIS Has Had a Troubled Past: The Genetic Disease Branch developed the existing information technology system in 1980. Since then, the system has been upgraded and maintained to hold over 10 million newborn records and over 3 million prenatal records.

Beginning in 1995, the Branch identified a need to re-engineer and modernize the information technology support. After a number of issues were finally resolved, in September 2000, an award was made to Deloitte Consulting for an 18-month project. **However, because of a protest, the contract was not finalized until 2001 and the Feasibility Study Report (as required for all information technology projects) was not approved by the DOF until 2002. Due to concerns with the project, the Legislature crafted Budget Act Language, as contained in the Budget Act of 2002, requiring a legal review prior to project commencement. System development on the project finally began in October 2003.**

This system--**the Screening Information System (SIS)**—is intended to re-engineer the information technology system that supports the clinical services provided by the statewide newborn and prenatal screening services. **The SIS is a $25.9 million project. Of the total amount, $14.2 million is for one-time development costs and $11.6 million is for ongoing costs for seven years. Funding is provided through the Genetic Disease Testing Fund and also includes a $5.3 million General Fund loan from 2003-04, and a proposed loan of $5 million for 2004-05. Screening fees were increased $4 to help fund the project in 2002.**

It should be noted that the existing system cannot support additional data bases resulting in the *inability* to expand the Newborn Screening Program to cover additional disorders such as congenital adrenal, hyperplasia and cystic fibrosis. DHS states that screening for these and other conditions cannot be added until there is a new information technology support system.

Concerns of the Legislature and Additional Reporting Requirements: **As a condition of the General Fund loan and due to past concerns with the management of the project, the Legislature required the DOF to conduct a review of the SIS Project and also required the DHS to provide quarterly reports to the Legislature beginning October 1, 2003.**

The DOF conducted their review and provided this information to the Legislature (discussed below). However, the DHS still *has not provided* any quarterly reports. Specifically, the DHS quarterly reports are suppose to provide the Legislature with updates on (1) the status of the project, and (2) expenditures, revenues , and the overall fund condition status of the Genetic Disease Testing Fund.

Department of Finance Review and Oversight Report (April 1, 2004): In March, the DOF conducted an assessment of the SIS Project. **Their required report to the Legislature noted the following key aspects:**

- Project deadlines have been missed and **the project is about 6 weeks behind** the DOF approved project schedule (schedule approved by the DOF in January 2004). **However, it is clear that the project is necessary and remains worthwhile to complete.** Progress on the development is occurring though improvements are needed (as referenced below).
- A Project Steering Committee was formed and the team is in place. **However, the DOF expressed concern that the Steering Committee lacked making timely decisions.**
- All project vendors have now been procured for project management, development and project oversight. They note that the project oversight vendor is producing oversight reports and appears to be identifying appropriate project risks.]
- **The project financial data provided by the DOF did not demonstrate a level of detail sufficient for the project team to adequately track costs against the project budget.** An inability to accurately track all project costs makes it difficult to report actual project costs after completion, or to validate the current and ongoing costs associated with implementing and supporting the system.
- **The majority of the project management plan has not been approved and the resulting lack of clarity regarding the roles and responsibilities has caused delays on the project.**
- **There was a lapse in the contract for the vendor project manager, which likely caused delays in reviewing and completing some project deliverables.**
- **The project schedule reviewed by the DOF was incomplete and insufficient to achieve the approved project timeframes.** Baseline information was not included and progress updates were not current.

Finally, the DOF states that they are supportive of the project provided the following DHS actions are completed by *May 1, 2004*:

- Provide the DOF with an accurate, realistic, and comprehensive project schedule for approval.
- Finalize and approve all project plans. Present a strategy to ensure roles and responsibilities are not just included in plans, but are implemented, practiced and supported.
- Provide complete project cost information which demonstrates the capability to track costs against budget for each category in the Feasibility Study Report with separation by fiscal year and by one-time and ongoing costs.
- Provide either a cost management plan, or a description of the cost tracking practices to be employed on the project.
- The Project Oversight Consultant will continue to provide monthly reports to the DOF.

In closing, *the DOF states that based upon the May 1 DHS response*, subsequent implementation of these planned actions and/or additional risks identified by the Project Oversight Consultant, *the DOF may schedule a follow-up assessment of the project.*

Governor's Proposed Budget: The Governor's **budget proposes an *additional* $5 million** (General Fund) loan to the Genetic Disease Testing Fund for the ongoing development of the SIS Project for 2004-05. **According to the latest projections, it is anticipated that sufficient revenues would be available from the Genetic Disease Testing Fund (funded by fees) to repay the two General Fund loans (loan from 2003-04 and budget year) in 2009.**

Legislative Analyst's Office Concern: In her Analysis, the LAO recognizes the importance of the project yet **is considerably concerned that no quarterly reports on the project have been provided. Because the Legislature has not been provided with the information it needs to assess the status of the project and the financial condition of the Genetic Disease Testing Fund, the *LAO is recommending to deny the loan unless* (1) the reports are submitted, and (2) the DHS is able to demonstrate in these reports its ability to manage the project.**

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1. DHS**, When will the Legislature receive **the most recently completed quarterly report,** (i.e., the April 1, 2004 report) **or some other analysis (such as the required DOF report) that provides the Legislature with appropriate information?**
- **2. DHS, has the required May 1 information on the SIS Project been provided to the DOF?**
- **3. DOF, when will your analysis of the May 1 information be available and is the DOF going to be conduct a follow-up assessment of the project?**

Budget Issue: Does the **Subcommittee want to provide the General Fund loan when key progress reports that were required by the Legislature as a condition of providing the loan have not been provided and questions remain regarding the management of the project (as referenced in the DOF analysis)?**

ISSUE "B" Request for State Staff for Genetic Disease Testing Program

Background: The Genetic Disease Testing Program (Newborn Screening Program and Prenatal Screening Program) has been plagued by administrative processing issues for several years. **In a 1997 Bureau of State Audits Report, the following was noted:**

- Bill health plans directly for prenatal testing fees.
- Continue to bill patients who fail to pay.
- Establish a process for attaching to a patient's tax refund if the patient does not pay the bill.
- Collect from Medi-Cal in a timely manner.
- Develop procedures to refund over payments of prenatal testing fees.

The DHS states that while they have made progress to satisfy these concerns, **it is not able to both maintain basic customer service *and* work on implementing improved billing, collecting, and accountability policies.**

In April 2003, a DHS internal audit noted that the Branch does not adequately separate duties over receipting and depositing payments. The audit also noted that Branch staff did not make regular site visits to monitor performance of its "lock box" contractor (receives and deposits checks) and its clearinghouse contractor (takes insurance information data entered by DHS staff and puts it into HIPAA compliant format for transmittal to third-party payers. **The DHS states that these site visits have lower priority than direct customer service and can only be done by adding staff.**

Budget Act of 2003—Control Section 4.1 Adjustment: Through Budget Control Section 4.1, the DHS administratively **reduced the Genetic Disease Testing Program by $721,000 ($673,000 Genetic Disease Testing Fund and $48,000 General Fund) and 9 state positions**. **These reductions were made in the current-year (late Fall of 2003) even with the DHS report findings of April 2003.**

Governor's Proposed Finance Letter Request: The DHS is requesting **an increase of 7 positions for an increase of $394,000 (Genetic Disease Testing Fund) to conduct administrative work.** They contend that these positions are needed to address existing backlog and on-going workload for revenue collection (obtaining the fees) and customer service. **Specifically, the DHS is seeking to hire:**

- Accountant Supervisor — permanent
- Two Account Clerk II — permanent
- Three Account Clerk II — two-year limited-term appointments
- One Office Assistant — two-year limited-term appointment

The DHS offers the following information to illustrate why they are requesting these positions:

- The branch **is five months behind on submitting bills** in the Prenatal Screening Program to insurance companies. They state that this results in delayed revenue collection of about $1.9 million

(Genetic Disease Testing Fund). Delay in submitting bills in respect to date of service can result in denial of claims by both insurance companies and Medi-Cal, which can become uncollectable.

- Bills for the New Born Screening program are also backlogged. They have received numerous telephone calls and mail from families upset over the delayed billings because sometimes the insurance companies have not paid them due to being late.
- Every year the Branch forwards **about $12 million in unpaid bills (about 18 percent of the total revenues collected) to the Franchise Tax Board (FTB)for offset against tax returns.** As such, about **15 percent of the daily correspondence** received is regarding these FTB notices.
- A major daily workload is check processing which includes endorsing, researching account numbers, crediting/debiting patient accounts, depositing checks and related activities. To be in compliance with the State Administrative Manual, these activities must be completed on a daily basis and require a separation of duties over receipting, depositing, and inputting the payment information into the computer system. The DHS states that these activities must take priority over direct customer response.

Subcommittee Request and Questions: The Subcommittee has requested for the DHS to respond to the following questions:

- **1. Why did the DHS reduce the program by 9 positions through the Control Section 4.1 process even when an internal audit (April 2003 report) expressed significant concerns?**
- **2. What program efficiencies can be implemented to streamline and simplify the outlined workload? (such as improved billing collection and accountability processes)**
- **3. Please provide an update on the backlog, and how long these programs been operating in a "backlog" mode?**
- **4. If these positions are approved, when would individuals be hired and will "freeze exemptions" be approved by the DHS? What is the projected length of time for the backlog to be processed and completed?**
- **5. What assurances can the Administration provide the Legislature that this program will be better administered and operated efficiently?**

Budget Issue: Does the **Subcommittee want to adopt or modify this request for 7 new positions?**

ISSUE "C"--Proposal to Expand the Newborn Screening Program--Tandem Mass

Background: Under the Newborn Screening Program, newborns are screened for a series of heritable preventable metabolic disorders, such as phenylketonura (PKU), hypothyroidism, galactosemia (GALT), and Sickle Cell Disease. At the time of birth, the heel of the infant is pricked and a drop of blood tested for different disorders. These birth defects have no immediate visible effects on a baby but, unless detected and treated early, can cause physical problems, mental retardation, and death.

When test results are abnormal, early diagnosis and proper treatment can make the difference between lifelong impairment and healthy development. Further, significant cost savings can be achieved through early detection and in some cases, simple dietary treatment of some disorders. Cost benefit analyses have found that expanded newborn screening produces significant net benefits. The DHS estimates that for every dollar spent on expanded screening, two dollars and fifty-nine cents ($2.59) is saved in average lifetime medical costs alone.

Pilot Project Ends (See Hand Out): **California's Tandem Mass Spectrometry Pilot Program screened for 24 disorders between January 2002 and June 2003 (as required by AB 2427, Kuehl, Statutes of 2000). Under the Tandem Mass Spectrometry Pilot, the DHS offered families, who consented to participate in the test screening, additional newborn screening for disorders at no increased cost. Over 320,000 newborns were tested in this pilot. The pilot program ended when one-time state funding (Genetic Disease Testing Fund) was expended.** ***However, though the enabling legislation required the DHS to submit a report to the Legislature on the outcomes of the pilot, no report has been provided.***

In a letter from Senator Alpert, as Chair of the Senate Select Committee on Genetics, Genetic Technologies and Public Policy, to Secretary Kimberly Belshe', it was noted that only limited information was made available regarding the pilot (no report), and that *California has fallen miserably behind* in its efforts to prevent mental retardation and infant morality from treatable metabolic disorders.

Though data from the pilot has not been provided to the Legislature as yet, in a February 2004 hearing chaired by Senator Alpert's select committee**, the DHS noted that expansion of the state's existing Newborn Screening Program is under consideration and they are looking at the specific benefits, costs, and logistics that would be involved in statewide implementation of the Tandem Mass Spectrometry.**

Management of the Pilot Project: It should be noted that management of the pilot was done separately from the state's "routine" New Born Screening Program. **The pilot used *private contractors* for laboratory analysis, computer support and follow-up data collection.**

Mass spectrometers are used in many laboratories throughout the world to analyze thousands of compounds such as those present in our bodies, our environment, foods, medicines, and criminal evidence.

Other States Ahead of California and California Charges Higher Fee (See Hand Out): As noted in a recent federal GAO Report—Newborn Screening, Characteristics of State Programs (March 2003)—**many other states are screening newborns for many more disorders. Further, California's program has a higher expenditure per infant screened than most other states.**

Birth defects are the leading cause of infant death in California and the United States. Yet California conducts newborn screening for only the following disorders: PKU, GALT, sickle Cell Disease, and congenital hypothyroidism. Recent technological advances have made it possible and affordable to screen for larger numbers of treatable metabolic disorders, more than 20 from a single blood sample as done with tandem mass spectrometry. **At least 26 states have implemented this new technology.**

Senate Bill 142 (Alpert), As Amended--May 3rd: Among other things, SB 142 would expand the existing Newborn Screening Program to include tandem mass spectrometry screening for selected disorders of fatty and organic acid disorder and congenital adrenal hyperplasia by no later than July 1, 2005. If the department is unable to provide statewide screening of these disorders, the legislation would require the department to temporarily utilize one or more laboratories through a competitive bid process. Fees for the program would be done through the regulation process in consultation with the Department of Insurance and the Department of Managed Health Care.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1. Please provide a very brief summary of the key results of the Pilot Project. Was it successful and does it make sense that California should seek expansion of the existing Newborn Screening Program? When will the report on the Pilot Project be available?**
- **2. Why hasn't the DHS expanded the Newborn Screening Program when other states provide screening for many more services?**

Budget Issue: Does the Subcommittee **want to adopt SB 142 as placeholder trailer bill language** as an effort to continue discussions with the Administration on expanding and improving the Newborn Screening Program?

3. Governor's Proposed Trailer Bill Language—Eliminate Methadone Lab Regulation

Background: The DHS is required to operate a Methadone Laboratory Regulation Program. This program was first codified in 1972 under Welfare and Institutions Code and later re-codified in 1977 under the Health and Safety Code. **Laboratories regulated under this program conduct lab tests to determine if any type of controlled or illegal drugs is present in specimens taken from individuals in drug treatment programs (such as the Methadone Maintenance), on probation or incarcerated, or required to test for employment purposes.**

This DHS regulation program is responsible for licensing and regulating the laboratories that conduct testing for about 32,000 Methadone Maintenance patients in the state. According to the DHS, there are presently *three laboratories in California and one out-of-state laboratory approved by the DHS to conduct testing*.

Specifically, the major activities of the DHS Methadone Laboratory Regulation Program include (1) proficiency testing of the laboratories, **(2)** qualification of supervisory laboratory staff, and **(3)** periodic on-site inspections of the laboratories. According to some representatives of the lab industry, the DHS' rigorous proficiency standards assure validity and reliability by utilizing "blind sampling" that sends "spiked" samples along with those submitted by clinics. **These are tested and validated for accuracy and the state's standards are more stringent than the federal standards. For example, California's lab results exceed the 90 percent reliability standard.**

Budget Control Section 4.1 Reduction Eliminated Program: Through this control section, the DHS eliminated the existing resources for this program—specifically, a Public Health Chemist III and a Staff Services Analyst—for savings of $131,000 (General Fund). As noted in the budget discussion below, the DHS intends to shift regulatory responsibility for oversight to the Clinical Laboratory Improvement Act as operated by the DHS.

Background—DHS Lab Activities & the Clinical Laboratory Improvement Amendment (CLIA): **According to the DHS, there are currently about 17,500 laboratories doing business in California, including those in physician offices, clinics and the like.**

The DHS Laboratory Field Services section is responsible for the oversight of clinical laboratories, clinical laboratory personnel, blood banks and all cytology laboratories in the state. These activities are to be supported with fee revenue obtained from those entities for whom the state provides oversight and monitoring. **These fees are deposited in the Clinical Laboratory Improvement Fund (CLIF) and are used for this purpose.**

In 1992 Congress, though the Clinical Laboratory Improvement Amendment (CLIA), implemented federal standards on all clinical laboratories. Of key importance in this action was that it immediately brought about *10,000 physician office laboratories and clinics* in California under oversight. These facilities had previously been exempted by state law from inspections or fee requirements.

In the early 1990's the DHS determined that it would be in the best interest of laboratories for California to seek an exemption from federal oversight (CLIA exemption) and SB 113 (Senator Maddy), Statutes of 1996 was chaptered. As part of this package, emergency regulations were enacted by the DHS that temporarily postponed the collection of duplicate fees from those laboratories newly brought under state oversight (i.e., physician office laboratories and others) until CLIA exemption could be achieved.

However, the DHS was notified in 2000 that the federal CMS was going to impose an administrative overhead fee of $2.4 million annually on California to sustain CLIA exemption. Therefore, the *DHS declined to further pursue CLIA exemption*. *Further, the emergency regulations that postponed fee collection of laboratories in California has continued to this time.* In the Hand Out Package, there is a chart which depicts which laboratory classifications are presently paying fees and which are not.

The bottom line is that the DHS notes that there are not enough fee revenues to conduct all of the laboratory activities associated with complaint investigations, proficiency testing, consultation, Medi-Cal approvals, fraud investigations , onsite inspections, and other enforcement activities. They state that this has resulted in the postponement of licensing examinations, delays in implementation of new licensing regulations and delays in many other functions.

Clinical Laboratory Technology Advisory Committee Meeting of March 2004: According to information provided at public meeting regarding clinical laboratory activities, **it was noted that due to the lack of sufficient resources the following issues, *among others*, have been found:**

- 42 laboratories in California are awaiting onsite inspections prior to opening (backlog 6 months)
- 40 laboratories outside of California have been waiting for inspections for at least 6 months.
- 450 laboratory license renewals are backlogged by 4 months.
- 32 laboratories are awaiting approval to do HIV testing.
- 650 phlebotomy applicants (pertains to blood) are awaiting certification.
- Tissue Bank licenses are being issued without inspection.
- Blood Banks are only being inspected every 3 to 3 and one half years.
- 75 individuals awaiting genetic scientists licensure.

Governor's Proposed Budget—Proposed Trailer Bill Language (See Hand Out): The Governor is **proposing to (1)** eliminate existing statute which requires the DHS to operate a Methadone Laboratory Regulation Program in California, and **(2)** shift regulatory responsibility for the oversight of these laboratories to the Clinical Laboratory Improvement Amendment (CLIA) as operated by the DHS.

The DHS states that this proposal is only eliminating the state-only requirements for Methadone laboratory certification and that the laboratories would still operate under their federal laboratory certifications. The DHS contends this proposed action would ensure continued public health support to the states narcotic treatment clinics and their patients while reducing government duplication.

The DHS further states that the Department of Alcohol and Drug Programs (DADP) has no concerns with this DHS change though the DADP will need to re-write its Narcotic Treatment Program regulations to reflect the change (which the DHS claims is minor). The Subcommittee has received no communication from the DADP on this issue and can therefore, not verify their perspective directly.

Constituency Concerns: The Subcommittee is in receipt of letters which oppose the elimination of the states oversight for Methadone Drug Laboratories. Specifically, they note that the certification of these "forensic toxicology" laboratories is distinguished from the CLIA certification because CLIA does not require, nor have a mechanism to perform, proficiency testing for laboratories that perform forensic toxicology tests. However, the federal Substance Abuse and Mental Health Administration (SAMSHA) has an approval process for laboratories and competency testing. As such, some laboratories may want to seek federal approval versus state oversight.

In lieu of the Administration's proposal, they are requesting a two-year sunset for the existing state oversight and for the DHS to make a formal request that the federal Substance Abuse and Mental Health Administration (SAMSHA) expedite the approval process for state laboratories that are in transition from state to federal methadone drug analysis of laboratories.

Subcommittee Staff Comment and Recommendation: Based on the above outlined information regarding the need to have stringent proficiency testing for methadone laboratories, problems with resource allocations in the CLIA program, and a federal option with SAMSHA that can be explored, **it is recommended to reject the Administration's proposal to eliminate the statute.** Further, due to the myriad of issues in the laboratory oversight area, it is recommended to not propose a two-year sunset date until such time as the DHS has better resolved how it will address on-going CLIA issues, as well as have discussions with the federal SAMSHA about their process.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please explain the budget proposal to eliminate the statute.
- **2. Please provide an update on CLIA and CLIF resources. Does the DHS have any short-term or longer-term solutions here?**

Budget Issue: Does the Subcommittee **want to reject the Administration's proposal to eliminate this statute?**

4. Cancer Research Program Funding—Control Section 4.1 and Budget Year

Background and Clarification of Prior Years Funding: Chapters 755 and 756, Statutes of 1997 (AB 1554, Ortiz and SB 273 Burton), created the Cancer Research Act of 1997. From 1998 to 2001, the annual Budget Act provided $25 million (General Fund) for this program.

Due to fiscal constraints, the Budget Act of 2002 and accompanying legislation (1) reduced the appropriation level to $12.5 million, **(2)** allowed for the receipt of private donations to the program, **(3)** capped the indirect costs for the grants at 25 percent, ***and*** **(4)** provided for multiple-year contracting for the grants. **However, a Mid-Year Reduction (Control Section 3.90) adjusted this appropriation to $6.25 million (General Fund) for 2002-03.**

The Omnibus Health Trailer Bill (Chapter 1161, Statutes of 2002) provided for unencumbered and unexpended balances from prior fiscal years (1999-2000, 2000-01 and 2001-02) for the Cancer Research Program to be re-appropriated and to be available for encumbrance and expenditure until July 30, 2005 (this date was chosen due to the multiple year nature of research grants). **This re-appropriation provided an additional $2.6 million. Therefore, total resources available for expenditure for 2002-03 was $8.8 million (including the appropriation and re-appropriation). Actual expenditures were $6.1 million (as of June 2003). Therefore, about $2.7 million was remaining as a balance for re-appropriation.**

The Budget Act of 2003 appropriated $3.125 million (General Fund) for the program. The appropriation was made in Provision 14 of Item 4260-001-0001. The Administration, using Budget Control Section 4.1, eliminated the entire General Fund appropriation. ***(This action is discussed further below.)***

The Budget Act of 2003 also included re-appropriation language that allows for the expenditure of unspent Cancer Research Funds appropriated in the Budget Act of 2002. As such the $2.7 million was the amount that was unspent; however, the DHS states that $1.9 million is the anticipated expenditure and encumbrances as of May 5, 2004. **Therefore, about $800,000 is likely to be available for re-appropriation.**

Legislative Counsel Opinion and Budget Control Section 4.1 of the Budget Act of 2003: At the request of Senator Ortiz, Legislative Counsel conducted an analysis of Budget Control Section 4.1 (Control Section) and the application of it by the DOF specifically to the Prostate Cancer Program. **Through this analysis, Legislative Counsel notes the following key factual aspects:**

- The Control Section **limits the reductions** to a state operation appropriation, and a program, project or function designated in any line of any schedule set forth by that appropriation, **may not be reduced by this section by more than 15 percent** (See **Subdivision h of the Control Section**).
- Item 4260-001-0001 (DHS state support item) was reduced by about $15.5 million from an appropriation of $264.1 million. This equates to less than 15 percent overall. **However, the DOF specifically eliminated funding for the Cancer Research Program.**

- Budget Act Language**-- Provision 14 of Item 4260-001-0001--directs that $3.125 million of the amount appropriated in this Item shall be appropriated for the Cancer Research Program. As such, the Legislature authorized a definite sum of money for a specific purpose—the Cancer Research Program.**

In an extensive analysis, **Legislative Counsel concludes that, in their opinion, the Control Section does not authorize the Director of Finance to eliminate or reduce an appropriation made in the Budget Act for a program in an amount that exceeds 15 percent if the program is a designated program for which an appropriation has been made (such as the Prostate Cancer Program).**

They state that the DOF's construction of the Control Section in this case is clearly erroneous because applying a 15 percent reduction to a schedule (meaning the entire Item 4260-001-0001) could result in the total elimination of an appropriation for a program for which the Legislature has made a specific designation, which is clearly not intended as noted in Subdivision h of the Control Section.

Governor's Proposed Budget: The Governor's budget proposes no appropriation for the Cancer Research Program. However, re-appropriation language (in Item 4240491-0589) is included which allows for expenditures of any unspent Cancer Research Funds appropriated in the Budget Act of 2002 (less than $800,000).

Subcommittee Request and Questions: The Subcommittee has requested for the DOF and DHS to respond to the following questions:

- **1. DHS, Please describe the budget proposal (for 2004-05), including the re-appropriation.**
- **2. DOF, Please explain the Control Section 4.1 process and the elimination of the funds for Cancer Research.**

5. Continued Implementation of Proposition 50 by the DHS

Background on DHS' Drinking Water Program: The DHS has been responsible for regulating and permitting public water systems since 1915. **The Drinking Water Program provides for ongoing surveillance and inspection of public water systems, issues operational permits to the systems, ensures water quality monitoring is conducted and takes enforcement actions when violations occur. The program oversees the activities of about 8,500 public water systems that serve more than 34 million Californians (about 98 percent of the population).**

The DHS is designated by the federal Environmental Protection Agency as the primacy agency responsible for the administration of the federal Safe Drinking Water Act. Under the federal Safe Drinking Water Act, California receives funding to finance low-interest loans and grants for public water system infrastructure improvements. **In order to draw down these federal capitalization grants, the state must provide a 20 percent match.** Proposition 13 bond funds had been used as the state match for this purpose in previous years. **However, the state match for future capitalization grants is now provided by Proposition 50, as contained in the Proposition. Proposition 50 bond funds are also used for additional purposes as discussed below.**

CALFED Program Relationship: The **DHS is also a participant with other state and federal agencies in the CALFED Program.** The CALFED Program, pursuant to SB 900, Statutes of 1996 was authorized to develop by means of Programmatic Environmental Impact Statement/Report a preferred alternative of programs, actions, projects and related activities which will provide solutions to water management problems in the Bay-Delta Region. The DHS' involvement relates to drinking water improvement projects.

Background on Proposition 50 and Chapters Applicable to the DHS Drinking Water Program: Proposition 50—the Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002—was approved by the voters **to provide *$3.4 billion* in funds to a consortium of state agencies and departments to address a wide continuum of water quality issues.** The bond measure contains 11 chapters, or subdivisions, which delineates the funding level to be provided over the course of the bond and the activities and functions which are to be addressed. **It also contains language throughout the measure that provides authority to the Legislature to *"enact such legislation as is necessary"* to implement certain chapters.**

Several chapters within the Proposition 50 bond measure pertain to functions conducted by the DHS as it pertains to the Drinking Water Program, including Chapter 3 and Chapter 4**. The DHS anticipates receiving as much as $528 million over the course of the bond measure. This funding is discussed below.**

Background on Chapter 3—Water Security ($50 million total from bonds proposed for DHS): Proposition 50 **provides a total of $50 million for functions that pertain to water security, including the following:** (**1)** Monitoring and early warning systems; **(2)** Fencing; **(3)** Protective structures; **(4)** Contamination treatment facilities; **(5)** Emergency interconnections; **(6)** Communications systems; and **(7)** Other projects designed to prevent damage to water treatment, distribution, and supply facilities. It is anticipated that this total amount will be utilized over a four-year period.

Background on Chapter 4—Safe Drinking Water ($435 million total from bonds for DHS): Proposition 50 provides that $435 million be available to the DHS for expenditure for grants and loans for infrastructure improvements, and related actions to meet safe drinking water standards. **About $17 million will be used as the state's matching funds to access the federal capitalization grants for public water system infrastructure improvements. These state matching funds will be spent over 5 years.**

With respect to the other projects, the Proposition states that the funds can be used for following types of projects: ,**(1)** Grants to small community drinking water systems to upgrade monitoring, treatment or distribution infrastructure; **(2)** Grants to finance development and demonstration of new technologies and related facilities for water contaminant removal and treatment; **(3)** Grants for community water quality; **(4)** Grants for drinking water source protection; **(5)** Grants for treatment facilities necessary to meet disinfectant by-product safe drinking water standards; and **(6)** Loans pursuant to the Safe Drinking Water State Revolving Fund (i.e., the existing program whereby the state draws down an 80 percent federal match).

In addition the Proposition requires that not less than 60 percent of the bond funds pursuant to Chapter 4 be available for grants to Southern California water agencies to assist in meeting the state's commitment to reduce Colorado River water use as specified.

Governor's Proposed Budget & Finance Letter Request: The **Administration proposes to provide the following funding for 2004-05 to the DHS:**

- ***For Chapter 3 Functions (Total of $10.4 million for 2004-05):*** **(1)** $10.1 million for local assistance projects, and **(2)** $262,000 for on-going state support and administration.
- ***For Chapter 4 Functions (Total of $99.8 million for 2004-05):*** **(1)** $17 million for state match funds to access federal capitalization grants for public water system infrastructure improvements, **(2)** 80.8 million for local assistance projects, and **(3)** $1.9 million for administration.

Subcommittee Staff Comment—Issue of Private Entities and the DHS Draft Guidelines: The **DHS has issued draft guidelines for Proposition 50 bond funds that would allow private water agencies to compete for bond funds.** The Legislative Counsel as well as legal counsel for the DHS have issued legal opinions that contend private water agencies are eligible for bond funds. The California Public Utilities Commission regulates investor owned water utilities and mutual water companies. Traditionally, these utilities have been relatively small utilities that serve small jurisdictions. **However in recent years, larger investor owned utilities have purchased many of these small utilities.**

It should be noted that SB 909 (Senator Machado) is currently pending before the Legislature and would specifically allow grants of state bond funds to be made to investor owned water utilities and mutual water companies.

However, other interested parties contend that while Proposition 50 did not explicitly exclude private water companies within the text of the enabling statutory language, there is

similarly no explicit inclusion of private water company eligibility either. Further, they note that the official voters guide told voters that the bond funds would be available for expenditure by various state agencies and for loans and grants to local agencies and non-profit associations. They also contend that some of the larger investor owned utilities and mutual water companies have greater access to the capital markets for the purposes of financing projects than many municipal utilities.

To-date, the other state agencies administering water-related grant programs have not published guidelines that explicitly allow private water agencies to compete for bond funds.

Subcommittee staff has been advised that the Administration is currently considering this policy issue internally.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please **describe the budget proposal for the funding**, including both Chapters 3 and 4.
- **2.** What is the **schedule for distributing the bond funds** to local agencies?
- **3.** What is the **timeline for the Administration's timeline for determining whether to allow private water companies to compete for bond funds?**
- **4.** Are there **any other pending aspects of this bond appropriation and allocation that the Subcommittee should be made aware of?**

Budget Issue: Does the Subcommittee **want to (1) approve the appropriation as budgeted and (2) adopt Budget Bill Language that would allow for the DHS to provide bond funds to private water companies *only if* legislation which allows for this passes in the current session and is chaptered?**

6. Federal Bioterriorism—New Funds, More State Staff, and Application Coming

Background—Overall Summary: The Emergency Supplemental Appropriations for Recovery & Response to Terrorist Attacks on the US Act (Public Law 107-117 of 2002), and subsequent federal legislation, **provided states with additional federal funds to support and address both local and state concerns regarding the threat of bioterrorism.**

Under this federal law there are two funding streams made available to California—one from the federal Centers for Disease Control (CDC), and one from the federal Health Resources and Services Administration (HRSA). The CDC grant is in support of state and local public health measures to strengthen the state against bioterrorism via a "Cooperative Agreement" to the DHS. The HRSA grant is for the development and implementation of regional plans to improve the capacity of hospitals, their emergency departments, outpatient centers, emergency medical systems and related matters.

The grants require California to meet specified benchmarks and activities. As such California must submit a Cooperative Agreement application to the federal government for their review and approval. However, California is assured by the federal government that grant funds will be provided, once the application is approved.

The DHS notes that they are responsible for detecting and responding to bioterriorism acts. Regardless of source, surveillance of infectious diseases, detection, and investigation of outbreaks, identification of etiologic agents and their modes of transmission, and the development of prevention and control strategies are the responsibility of state and local public health agencies. **They also note that the ultimate responsibility for protecting the public and environmental health of the population on the ground lies with the Local Health Jurisdictions, especially during biological or chemical incidents.**

CDC Cooperative Agreement Grant Overall: This grant is for upgrading the state and local public health jurisdictions' critical capacities related to preparedness for and response to bioterriorism in **seven focus areas as follows:** Planning and Readiness Assessment, Surveillance and Epidemilogy Capacity, Communications and Information Technology, Health Risk Communications and Information Dissemination, and Education and Training. As a condition of the funding, the DHS must meet 16 critical capacities and 25 benchmarks.

HRSA Grant Overall: This grant is focused on activities for the Hospital Bioterrorism Preparedness Program. These funds are to be used for hospitals, outpatient facilities, local emergency medical systems, and poison control centers. A needs assessment of hospitals' and clinics' capabilities to respond to a bioterriorism event has been completed and funds have been provided to hospitals and clinics for planning and preparedness activities. A Joint Advisory Committee has been established, as required by the federal government, to allocate the grant funds to local entities and to address inter-hospital and regional planning issues regarding the management of a bioterrorism incident.

Budget Act of 2003 and Administration's Section 8 Letter: Since these bioterriorism grants operate on a federal fiscal year and also require states receiving funds to summit a detailed application which requires federal approval, **the timing of the process does not neatly correspond to California's state budget cycle or fiscal year. For example, the federal government provides states with guidelines for development of the applications in mid-May. States usually have 45 days after receipt of the federal guidelines. In addition, the federal government usually makes some changes to these applications. As such, the Legislature is at risk of appropriating funds with little detail as to its potential expenditure in some cases.**

In the Budget Act of 2003, the Legislature agreed that about half of the new federal funds for the August 31, 2003 to August 30, 2004 cycle be funded in the budget and the remaining amount be appropriated through SB 678 (Senator Ortiz). **This was done in order to give the DHS ample opportunity to work with major constituency groups—Local Health Jurisdictions, County Health Officers, hospitals, and related core emergency/disaster-related response entities—on specifically how the funds were to be spent (and to correspond to the state's federally –approved applications).**

SB 678 stalled on the Assembly floor at the end of session last year due to issues unrelated to the content of the legislation, the remaining federal funds were appropriated through authority provided via the Joint Legislative Budget Committee and the Section 8 process in the Fall of 2003. These funds are shown in the fiscal chart below. However, SB 678 was just recently signed by the Governor in April 2005 so all other aspects of the legislation are now in place.

Summary of Recent Federal Grant Funds—2002, 2003 and 2004: In the table below, the allocation of funds by ***focus area*** for the past several ***federal fiscal years*** is shown.

A. Grant Cycle—(Combined) August 31, 2001 to August 30, 2003 ***(Shown by Grant and Focus Area)***	**State Funding**	**State Positions**	**Local Health Funding**	**Hospital & Health Care Providers**	**TOTAL FUNDING**
1. CDC Grant	**$17.5 million**	**71**	**$41.7 million**		**$62.2 million**
A—Preparedness Planning & Readiness Assessment	4.5 million		17.9 million		22.4 million
B—Surveillance & Epidemiology Capacity	3.6 million		8.8 million		12.4 million
C—Laboratory Capacity-Biologic	3.8 million		3.6 million		7.4 million
D—Laboratory Capacity-Chemical	2 million				2 million
E—Health Alert Network & Communications			4.4 million		4.4 million
F—Communicating Health Risks & Health Information Dissemination	1.1 million		2.3 million		3.4 million
G—Education & Training	2.3 million		4.7 million		7 million
General Fund Backfill to repay local health subvention			3 million		3 million
2. HRSA Grant	**$1.4 million**			**$8.5 million**	**$9.9 million**
TOTAL (both grants)	**$18.9 million**	**71**	**$44.7 million**	**$8.5 million**	**$72.1 million**

B. Grant Cycle **August 31, 2003 to August 30, 2004** ***(Shown by Grant and Focus Area)***	**State Funding**	**State Positions**	**Local Health Funding**	**Hospital & Health Care Providers**	**TOTAL FUNDING**
1. CDC Grant	**$21.5 million**	**76**	**$48.6 million**		**$70.1 million**
A—Preparedness Planning & Readiness Assessment	3.3 million		11.3 million		14.6 million
B—Surveillance & Epidemiology Capacity	5.3 million		10.1 million		15.4 million
C—Laboratory Capacity-Biologic	2.9 million		6.6 million		9.5 million
D—Laboratory Capacity-Chemical	1.5 million				1.5 million
E—Health Alert Network & Communications	2.5 million		6.7 million		9.2 million
F—Communicating Health Risks & Health Information Dissemination	1.4 million		3.5 million		4.9 million
G—Education & Training	2.8 million		6.6 million		9.4 million
Strategic National Stockpile (forward deployment of medical and pharmaceutical supplies)	1.7 million		3.8 million		5.5 million
2. HRSA Grant	**$5.3 million**			**$33.5 million**	**$38.8 million**
TOTAL (both grants)	**$26.7 million**		**$48.6 million**	**$33.5 million**	**$108.8 million**

California Must Submit New Application to Obtain Federal Grant Funds: A new federal grant cycle is approaching which will require the state to submit an application for federal approval. **As with last year (as discussed above)**, **the Budget Bill will be completed prior to the completion of the Cooperative Agreement application being submitted, reviewed and approved by the federal government.** According to the DHS, states are to receive the guidelines in **mid-May** and are then expected to submit an application to the federal government within 45 days.

Governor's Proposed Budget & Finance Letter—New Federal Funds, New Positions & Budget Bill Language Requested: The Governor is proposing **two adjustments** regarding this federal bioterrorism funding. **First, the DHS is requesting an increase of $76.5 million (federal funds) for total expenditures of $108.9 million (federal funds) in 2004-05.**

Second, the DHS is requesting an increase of 28.8 new state positions in addition to an existing base of 76 positions for this purpose. Of these total new positions, 10 are requested to be made permanent and 18.8 are limited-term (through June 30, 2005).

As noted in the table below, of the total amount, (1) $36.5 million, is for state support and related functions, (2) $47.1 million would be provided to Local Health Jurisdictions, and (3) $25.2 million would be provided for local assistance associated with the HRSA grant requirements.

Third, the DHS is seeking approval of Budget Bill Language (both in the state support item and local assistance item) that would allow for expenditure and encumbrance of these federal funds through August 30, 2006. This is one year longer than the state's fiscal year and one year past the federal fiscal year for which the funds are allocated to California. **Specifically, this proposed language is as follows:**

> "Notwithstanding any other provision of law, moneys made available for bioterrorism preparedness pursuant to this Act shall be available for expenditure and encumbrance until **August 30, 2005**."

Summary of Bioterriorism Funding for 2004-05 *(State Fiscal Year)*

DHS Proposed Budget & Finance Letter for Bioterrorism 2004-05 (State Fiscal Year)	State Support (Positions)	Local Health Jurisdictions	Hospitals, EMS & Related Entities	TOTALS
1. CDC Grant ***(anticipated)***	$23 million (76 + 18.8 positions = 94.8)	$47.1 million	N/A	$70.1 million
2. HRSA Grant ***(anticipated)***	$13.5 million (0 + 10 = 10 positions)	N/A	$25.2 million	$38.7 million
TOTAL Amounts	**$36.5 million**	**$47.1 million**	**$25.2 million**	**$108.8 million**
Baseline Amount	**($7.3 million)**	**($25 million)**	**0**	**($32.3 million)**
CDC Baseline	$6.8 million	$25 million	N/A	$31.8 million
HRSA Baseline	$488	N/A	0	$488
Requested Increase	**$29.2 million**	**$47.2 million**	**$25.2 million**	**$76.5 million**
CDC Baseline	($16.2 million)	($22 million)	N/A	($38.2 million)
HRSA Baseline	($13.1 million)	N/A	($25.2 million)	($38.3 million)

With respect to state support, the DHS contends it needs an additional 28.8 positions in addition to the base of 76 positions because (1) the federal government added more requirements, and **(2)** positions are needed to track all fiscal aspects of the grants. The DHS states that all activities outlined in the Cooperative Agreement must be performed by the recipient agency (i.e., DHS) as a condition of the CDC award. In addition, the DHS states that HRSA has added numerous benchmarks required benchmarks as a condition of funding.

Although the DHS will address some of these requirements through interagency agreements and contracts, an additional 10 permanent positions and 18.8 limited-term positions (until June 30, 2005) are needed to ensure coordinated planning and response efforts between the state and Local Health Jurisdictions.

Constituency Comments: Some constituency groups have expressed a desire to place a portion of the federal bioterriorism funds into SB 431 (Ortiz) (as amended January 5, 2004) as was similarly done last year (as discussed above in this agenda).

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please explain when the state will be receiving guidance from the CDC and HRSA on the grant applications, and **the state's schedule for submitting the application. How will the state incorporate the needs of the Local Health Jurisdictions and other interested parties?**
- **2. Does the federal government (either CDC or HRSA) ever make changes to the state's application?**

- **3. Please provide a brief summary of the budget and Finance Letter proposal to increase funds and to add 28.8 additional staff.**
- **4. Are any of the existing 76 authorized positions vacant? If so how many and what are the DHS' plans for filling them?**
- **5. Is California at risk of losing any existing federal grant funds in the current-year?**
- **6. Could any of the state DHS' federal bioterrorism funds be used to support the activities associated with SB 2065 (Kuehl), Statutes of 2002 regarding conducting an inventory of low-level radioactive waste (as discussed in the May 3rd Subcommittee Agenda)? If not, why not since these materials do pose a bioterriorism risk (such as a dirty bomb)?**

Budget Issue: Does the **Subcommittee want to modify the appropriation for the federal bioterriorism funds?**

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